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COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

SUMMARY OF FISCAL YEAR 1986 SPENDING AND REVENUE RECOMMENDATIONS

Pursuant to H. Con. Res. 152, as Passed
the House on May 23, 1985

JULY 23, 1985

Prepared for the Use of the Committee on Ways and Means by its staff

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C O N T E N T S

	Page
Summary tables	1
Medicare:	
Hospital rate of increase	4
Disproportionate share adjustment	5
Indirect teaching adjustment	6
Hospital transition to national payment rates	7
Direct Medical Education	8
Change calculation of Medicare Part B premium	9
Physician fee freeze extension	10
Physician payment arm of ProPAC	12
Return on equity for proprietary hospitals	13
Hospital area wage index	14
Extend working aged provision	15
Hospice extension	16
Responsibilites of hospitals in emergency cases	17
Preventive services demonstrations	19
HMO technical amendments	20
Technical corrections	22
Evaluation of preadmission certification programs	23
Reimbursement of assistant surgeons during cataract operations	24
Hospital-based physicians	25
Limit late enrollment penalty for Part A	26
End stage renal disease networks	27
Private health insurance continuation	28
Continue Medicare waivers for certain areas	29
Coverage of newly hired State and local employees	30
Proposed committee report language	31
Trade adjustment assistance	32
Customs Service	33
Railroad unemployment compensation	35
AFDC	37
Pension Benefit Guarantee Corporation	41
Revenues	42

PREFACE

This document was prepared by the staff of the Committee on Ways and Means, U.S. House of Representatives, for the use of the Committee Members in their consideration of the spending and revenue provisions related to the requirements of the House-passed fiscal year 1986 budget resolution. This material includes summary explanations of recommendations approved by the Committee's Subcommittees on Health, Trade and Public Assistance and Unemployment Compensation. Explanations of certain revenue-raising proposals are also included.

It should be noted that the House-passed budget resolution provides the Committee on Ways and Means flexibility in meeting the reconciliation instruction by a reduction in outlays, an increase in revenues, or any combination thereof.

BUDGET DEFICIT REDUCTION PACKAGE

HOUSE BUDGET RESOLUTION

The House budget assumes the following for programs within the jurisdiction of the Committee.

	Fiscal year, in millions			
	1986	1987	1988	3-year Total
Outlays				
Medicare	3,423	4,277	5,145	12,845
Custom Service User Fees	473	493	513	1,479
Increase in PBGC Premiums	300	300	300	900
Total Outlay Reduction	4,196	5,070	5,958	15,224
Revenues	1,450	1,700	3,100	6,250
Total Deficit Reduction to be achieved	5,646	6,770	9,058	21,474

NOTE: The President's budget and the House and Senate Budget resolutions all include increased revenues from an expanded superfund. The precise size of the superfund has not been determined by the House Energy and Commerce Committee or the House Public Works and Transportation Committee. It is anticipated that any shortfall from the $21.5 billion deficit reduction target will be offset by increased superfund revenues, when the size of the superfund is established.

SUMMARY OF PROPOSED WAYS AND MEANS DEFICIT REDUCTION PACKAGE

	fiscal year, in millions			
	1986	1987	1988	3-year Total
Recommendations from:				
Subcommittee on Health*	2,416	3,636	4,106	10,158
Subcommittee on Trade*	223	523	924	1,670
Subcommittee on Public Assistance and Unemployment Compensation*	(55)	(179)	(217)	(451)
Pension Benefit Guaranty Corporation Proposal	160	210	240	610
Revenue Proposals	1,940	2,425	2,620	6,985
Total Deficit Reduction Achieved in Enclosed Package	4,684	6,615	7,673	18,972

*Also includes some revenue items.

NOTE: These estimate are from either the CBO or Joint Committee on Taxation. Numbers in parenthesis indicate an increase in outlays.

Deficit Reduction Package

	fiscal year, in millions			
	1986	1987	1988	3-year Total
Medicare				
Hospital Rate of Increase	1,365	1,870	2,115	5,350
Disproportionate Share Adjustment	0	0	0	0
Indirect Teaching Adjustment	320	530	800	1,650
Transition to National Rates	0	0	0	0
Direct Medical Education	0	0	0	0
Income Related Premium*	230	240	(30)	440
Physician Fee Freeze Extension	225	250	320	795
Physician Payment Arm of PROPAC	0	0	0	0
Return on Equity Payments*	5	205	205	415
Hospital Area Wage Index	0	0	0	0
Working Aged Expansion	230	360	400	990
Hospice Extension	0	0	0	0
Antidumping Provision	0	0	0	0
Preventive Services Demonstrations	1	1	1	3
Health Maintenance Organization Technical Amendments	0	0	0	0
Technical Corrections	0	0	0	0
Evaluation of Preadmission Certification Programs	0	0	0	0
Assistant Surgeons' Fees for Routine Cataract Operations	20	20	20	60
Hospital-Based Physicians	0	0	0	0
Limit the Late Enrollment Penalty for Medicare Part A	(5)	(5)	(5)	(15)
ESRD Networks	0	0	0	0
Private Health Insurance Continuation	0	0	0	0
Allow Continued Medicare Wavers for Certain Areas	0	0	0	0
Cover Newly Hired State and Local Employees Under Medicare (Revenues)	50	175	265	490
Proposed Report Language: Medicare Hearing and Appeals Process	0	0	0	0
Medicaid and Premium Offsets*	(25)	(10)	15	(20)
Total	2,416	3,636	4,106	10,158

	fiscal year, in millions			
	1986	1987	1988	3-year Total
Trade Adjustment Assistance				
Reauthorize Firm Program and Amend Worker Program	0	0	0	0
Customs Service				
Reauthorize and Improve Operations of Custom Services (Revenues)	50	350	750	1,150
User Fees*	173	173	174	520
Railroad Unemployment Compensation				
Increase in Railroad Unemployment Repayment Tax	0	101	98	199
Aid to Families with Dependent Children				
Quality Control*	(5)	(25)	(80)	(110)
Teenage Pregnancy Block Grant	(50)	(100)	(0)	(150)
AFDC for Unemployed Two-Parent Families*	(0)	(155)	(235)	(390)
Pension Benefit Guarantee Corporation				
Increase in Premiums	160	210	240	610
Revenues				
Improvement in IRS Operations*	190	445	610	1,245
Increase in Black Lung Taxes	210	230	240	680
Tax Treatment of Rail Retirement Benefits	30	60	70	160
Cigarette Tax Made Permanent	1,510	1,690	1,700	4,900
Revenue Total	1,940	2,425	2,620	6,985
Total Deficit Reduction	4,684	6,615	7,673	18,972

NOTE: Numbers in parentheses indicate an increase in outlays.

*Estimates are preliminary and subject to change.

HOSPITAL RATE OF INCREASE

CURRENT LAW:

Current law provides that the medicare prospective payment rates should be updated annually by the Secretary of Health and Human Services. The law states that the update should reflect increases in hospital input prices but, for fiscal year 1986, may not exceed market basket (hospital input prices) plus one quarter of a percentage point.

The Secretary of HHS promulgated proposed regulations that would freeze DRG payments for FY 1986 at the FY 1985 level. This regulatory initiative would save $6.420 billion over three years.

PROPOSAL:

Require that the Secretary provide a 1% increase in the DRG payments for FY 1986. A similar rate of increase would be provided for PPS exempt hospitals which are still on a cost reimbursement system.

The Committee, in deciding to provide for a 1% increase, has taken into consideration the errors made when first establishing the prospective payment rates. Unaudited cost data were used in developing the PPS rates which the General Accounting Office has determined overstated by 4.39% the actual costs incurred by hospitals in the base year.

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED THREE YEAR SAVINGS:

$5,350 million

DISPROPORTIONATE SHARE ADJUSTMENT

CURRENT LAW:

Under the Social Security Amendments of 1983 the Secretary of HHS was required to make adjustments to the PPS rates for hospitals that serve a disproportionate number of low income or medicare patients. The Deficit Reduction Act included similar language. The Secretary has never made these adjustments.

Hospitals that serve a disproportionate share of low income patients have higher medicare costs per case. There are two categories of reasons for these increased costs: a) low-income medicare patients are in poorer health within a given DRG, that is they are more severly ill than average; they have more complications; secondary diagnoses; and fewer alternatives for out of hospital convalescence; b) hospitals having a large share of low income patients (medicare and non-medicare) have extra overhead costs and higher staffing ratios - medical social workers, translators, nutritional services and health education workers. These hospitals are frequently located in inner cities and have higher security costs. They often serve as regional centers and have high standby costs for trauma units, burn units, psychiatric emergency services, neonatal intensive care units and poison control units. They are often recipients of economic transfers of high cost patients from other hospitals.

PROPOSAL:

Would require the Secretary of HHS to make additional payments on the Federal portion of the DRG payment, for urban PPS hospitals with 100 beds or more, serving a disproportionate share of low income patients. The proxy measure for low income would be the percentage of a hospitals' total patient days attributable to medicaid patients (including medicaid eligible elderly - medicare/medicaid crossovers). The federal DRG payment would be increased by 7 percent for each 10 percentage point increase in the proportion of low income days to total days above the minimum threshold of 15%. The maximum adjustment would be no greater than 16%.

A limited exceptions process would be established for urban hospitals with 100 beds or more. The Secretary would be required to make disproportionate share payments where a hospital can demonstrate that at least 35% of its patient care revenue is provided by local or state governments for patient care for low income patients not covered by medicaid. If this threshold is met the per DRG add-on would be 16%.

EFFECTIVE: October 1, 1985. The disproportionate share adjustment would sunset September 30, 1987.

ANTICIPATED 3 YEAR COST: Budget Neutral

INDIRECT TEACHING ADJUSTMENT

CURRENT LAW:

The medicare program has always provided reimbursement for costs of approved medical education programs incurred by teaching hospitals. Under current law, there is cost reimbursement for direct educational costs and PPS adjustments to account for indirect costs. The indirect costs are increases in patient care costs associated with a teaching program. The adjustment recognizes increased costs associated with increased diagnostic testing, increased numbers of procedures prescribed, higher staffing ratios and more severely ill patients.

These additional costs have been estimated statistically for the purposes of adjusting medicare payments. Currently, the increases in payments vary directly with each hospital's ratio of interns and residents to its number of beds (IRB). For purposes of setting reimbursment limits under prior law, HCFA estimated that every 0.1% increase in IRB ratio would result in a 5.79% increase in medicare's cost per discharge.

When Congress passed the prospective payment system it set the indirect teaching adjustment at 11.59% -- double the original adjustment. These payments are added only to the Federal DRG portion. The adjustment was doubled because of concerns that the DRG system would adversely affect teaching hospitals, in part because of doubts about the ability of the DRG classification system to account fully for factors such as severity of illness, urban location, bed size and increased medicare costs associated with hospitals that serve large numbers of low income patients.

The FY 86 Administration budget has requested cutting the indirect teaching adjustment in half, to 5.79%. This would save $2.9 billion over three years.

PROPOSAL:

Set the indirect teaching adjustment to 8.1% for FY 1986, and FY 1987, and to 8.7% for FY 1988 and beyond, on a variable basis. CBO has estimated that medicare costs increase at a slower rate as teaching programs get larger. Therefore, the current method of using a constant adjustment for each 0.1% increment in the IRB ratio may over-compensate those hospitals with the highest IRB ratios. CBO suggests a variable adjustment to reflect this non-linear cost relationship.

As the Subcommittee has approved a disproportionate share adjustment for two years, the indirect teaching adjustment would be lowered to 8.1% to avoid duplicate payments arising from interactions between the two types of adjustments. When the disproportionate share provisions expire at the end of FY 1987, the indirect teaching adjustment would go back up to 8.7%.

EFFECTIVE DATE: October 1, 1985

ANTICIPATED 3 YEAR SAVINGS: $1,650 million

HOSPITAL TRANSITION TO NATIONAL PAYMENT RATES

CURRENT LAW DR7

The medicare prospective payment legislation provided for a three-year transition period, moving away from hospital specific costs (HSP) towards a fully phased in national payment rate in FY 87.

FY84 - 75% HSP/ 25% DRG (100% regional)
FY85 - 50% HSP/ 50% DRG (75% regional / 25% national)
FY86 - 25% HSP/ 75% DRG (50% regional / 50% national)
FY87 - 100% DRG (100% national)

Concern has been expressed that moving to a national rate in three years would significantly disadvantage those areas of the country that have higher hospital costs.

PROPOSAL

The 50% hospital specific/ 50% federal rate would be maintained for another year. The transition schedule in current law would continue after FY 1986. The schedule would, therefore, be:

FY86-50% HSP/ 50% DRG (75% regional/25% national)
FY87-25% HSP/ 75% DRG (50% regional/50% national)
FY88-100% DRG (100% national)

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED 3 YEAR COST:

None

DIRECT MEDICAL EDUCATION

CURRENT LAW:

Medicare has historically reimbursed teaching hospitals on a cost basis for its share of the direct costs of approved medical education activities.

On July 5 of this year the Administration issued regulations freezing the amount medicare will reimburse providers for their direct costs of approved medical education activities, for cost reporting periods beginning on or after July 1, 1985.

The freeze permits payment based on the lesser of a provider's allowable direct medical education costs for the current cost reporting period or for a base year (the provider's cost reporting period beginning on or after October 1, 1983.)

PROPOSAL:

The Secretary would be prohibited from implementing the regulations that impose the one-year freeze on medicare payments for the direct costs of approved medical education activities.

EFFECTIVE DATE:

July 1, 1985

ANTICIPATED 3 YEAR COST:

None

CHANGE THE CALCULATION OF THE MEDICARE PART B PREMIUM

CURRENT LAW:

The Secretary of Health and Human Services is required to calculate and announce in the fall of each year the increase in premiums of those who elect to enroll in the supplementary medical insurance (part B) portion of the medicare program. The new premium rates are effective on January 1 of the year following the year in which the calculation was made.

Under a temporary provision of the law, enrollee premiums are to produce premium income equal to 25% of program costs for elderly enrollees with the remainder financed by Federal general revenues. This temporary provision was extended in DEFRA for calendar years 1986 and 1987. The premium this year is $15.50 a month and is projected to be $16.10 a month in 1986.

Upon expiration of the temporary provision, the new premium rate will again be the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged or, (2) the current premium amount increased by the percentage by which cash benefits were increased under the COLA provisions of the social security program.

PROPOSAL:

The part B monthly premium would be frozen at $16.00 per month for calendar years 1986, 1987, and 1988, and a tax would be imposed on the excess of adjusted gross income over $20,000 for individuals and over $40,000 for couples who are both part B enrollees, and capped at $60,000 for individuals and $120,000 for couples, for all part B enrollees. The rate of tax on adjusted gross income over $20,000 for individuals and $40,000 for couples would be 1.4% for 1986; 1.5% for 1987; and 1.75% for 1988. The provision is designed to finance 25% of program costs for these three years.

EFFECTIVE DATE:

January, 1 1986

ANTICIPATED 3 YEAR SAVINGS:

$440 million

PHYSICIAN FEE FREEZE EXTENSION

CURRENT LAW:

Medicare customary and prevailing charges for all physician services are frozen for a 15-month period which expires on October 1, 1985. In addition, nonparticipating physicians are prohibited from charging their medicare beneficiaries more during the 15-month period than they charged during a base period, from April through June 1984.

PROPOSAL:

On October 1, 1985, any physician who signs a participation agreement effective for the year beginning October 1, 1985 would receive an increase in medicare payments.

For any physician who does not sign a participation agreement, the current 15-month freeze on medicare payments would be extended for 12 months, beginning October 1, 1985.

The current prohibition on increases in actual charges of nonparticipating physicians would also be extended for 12 months, beginning October 1, 1985. This freeze on actual charges would apply to all physicians who do not sign participation agreements effective for the year beginning October 1, 1985.

On October 1, 1986, any physician who signs a participation agreement effective for the year beginning October 1, 1986 would receive an increase in medicare payments.

Physicians who do not sign participation agreements effective for the year beginning October 1, 1986 would also receive an increase in medicare payments. However, increases for these physicians would be lagged one year behind those of participating physicians. This provision would impose on physicians who drop out of the participation program a freeze at the prevailing charge levels they received in the previous year; and would create a permanent differential between the prevailing charges to which participating and nonparticipating physicians are subject.

The Secretary would be required to transfer $15 million in medicare part B funds to the carriers for continued administration of the freeze and the participating physician program, and for the development of professional relations staffs dedicated exclusively to addressing the billing and other problems of participating physicians.

Several additional incentives would be provided to encourage greater physician participation. The Explanation of Medicare Benefits (EOMB) for all unassigned claims would be required to include a message reminding medicare beneficiaries of the participating physician program and providing them with

the toll-free number for information in their area. The message would also remind beneficiaries that they incur no extra billing on services provided by participating physicians.

The statutory requirement for publication of the Physician Assignment Rate List (PARL), which lists the assignment rates for all physicians irrespective of their participation status, would be eliminated.

Participating physician directories would be sent to all participating physicians to facilitate and encourage the development of a referral network of participating physicians.

Report language would indicate that a copy of the appropriate directory(s) would also be sent to each Member of Congress, to facilitate distribution of information to beneficiaries on the participating physician program.

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED 3 YEAR SAVINGS:

$795 million

PHYSICIAN PAYMENT ARM OF PROPAC

CURRENT LAW:

There currently exists no advisory body whose purpose it is to make recommendations regarding medicare physician payment.

PROPOSAL:

The director of the Congressional Office of Technology Assessment would appoint to the Prospective Payment Assessment Commission (ProPAC) ten additional members whose mission and duties would be to make recommendations regarding medicare physician payment. The Commission would be organized into two separate and, basically, independent "subcommittees," the original Commission working on hospital payment and the ten new members working on physician payment.

The members would be composed of people with expertise and experience in the provision and financing of physician services, and would include physicians and other health professionals, third party payers, individuals skilled in biomedical, health services and economic research, and representatives of consumer and elderly groups.

The ongoing duties of the physician payment group would be to make recommendations by October 1 of each year regarding adjustments to reasonable charge levels for physician services and/or structural change in the medicare physician payment mechanism.

The group would make recommendations concerning such issues as reduction of existing specialty and geographic differentials; adjustment of reasonable charges to reflect resource costs; procedures for which payments for assistants-at-surgery should be eliminated; and procedures for which second opinions should be required.

The members would make recommendations on ways to strengthen the participation program and increase assignment, and on changes in the physician payment mechanism, based on the HHS study of physician DRGs and the OTA study of fee schedules.

The physician payment group would advise the Secretary on the development of a fee schedule based on a relative value scale (RVS), to be implemented by October 1, 1987.

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED 3 YEAR COST:

None

RETURN ON EQUITY FOR PROPRIETARY HOSPITALS

CURRENT LAW:

A return on equity (owner) capital invested and used in providing patient care is considered a medicare allowable cost for proprietary, or for-profit, health care providers (hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy providers and comprehensive outpatient rehabilitation facilities). Equity capital is the net worth of a hospital excluding those assets and liabilities not related to patient care. Specifically, equity capital includes: (1) the investment in the plant, property, and equipment (net of depreciation) related to patient care, plus deposited funds required in connection with leases; and (2) net working capital maintained for necessary and proper operation of patient care facilities.

The level of payment for return on equity (ROE) was formerly was set at a rate of no more than one and one-half times the average rate of return on trust fund investments. In the 1983 Social Security Amendments, the Congress reduced the level of payment for ROE with respect to reasonable costs of inpatient hospital services, to the average rate of return on trust fund investments. The rate of return for other providers was not affected.

PROPOSAL:

Return on equity would no longer be a medicare allowable cost for inpatient hospital services and would also be excluded in determining DRG payment rates.

For outpatient departments and all other providers, the rate of return would be reduced to one times the average rate of return on the hospital insurance trust fund.

EFFECTIVE DATE:

For inpatient hospital services, cost reporting period beginning on or after October 1, 1986. For DRG payment on October 1, 1986.

For outpatient departments and other providers, cost reporting periods beginning on or after October 1, 1985.

ANTICIPATED 3 YEAR SAVINGS:

$415 million

HOSPITAL AREA WAGE INDEX

CURRENT LAW:

As an integral part of the medicare prospective payment system (PPS) for hospitals, the federal DRG portion of the prospective payment rates is adjusted to take into account differences in wages from area to area. This is accomplished by means of an area wage index applied to all PPS hospitals in urban and rural areas. The current hospital wage index is constructed from a national data base of hospital wage records maintained by the Bureau of Labor Statistics (BLS). There are a number of technical flaws with this index, principally that it fails to recognize local differences in the number of part-time hospital workers.

Because of inaccuracies in the BLS wage index, Congress required HCFA to report to Congress on a refined wage index. The report proposed two alternative wage indices based upon a survey of over 5,000 hospitals. HCFA has provided in its proposed regulations for inclusion of the "gross hospital wage index" - this index includes salaries and wages for contracted labor, interns and residents, hospital-based physicians and personnel employed in areas other than the hospital inpatient area.

Originally, when it was contemplated that the revised wage index would be implemented quickly, Congress required that any new wage index be implemented retroactive to October 1, 1983. The revised wage index has still not been implemented.

PROPOSAL:

1. Require the Administration to implement the new gross wage index effective for October 1, 1985.

2. Eliminate the retroactive application of the new wage index as is required by current law.

3. Require the Secretary to study and make a recommendation to the Congress on refining the area wage adjustment to reflect the higher wage costs incurred by central city areas relative to surburban areas of the same metropolitan area.

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED 3 YEAR COST:

None

EXTEND THE WORKING AGED PROVISION

CURRENT LAW:

The Age Discrimination in Employment Act (ADEA) requires employers of 20 or more people to offer employees and their spouses age 65 through 69 the same health insurance coverage they offer to their younger employees and under the same conditions.

If the older employee chooses the employer's plan, medicare becomes the secondary payor if the employer plan does not pay full benefits.

If the older employee chooses not to participate in the employer's plan, medicare will be the primary payor. The employer is prohibited from offering a health plan designed to supplement medicare (i.e. fill in medicare's deductible and coinsurance).

Currently, ADEA applies only to persons between the ages of 40 and 70.

PROPOSAL:

The proposal would extend the health insurance requirement of ADEA to persons over the age of 69, thereby removing the upper age limits.

EFFECTIVE DATE:

January 1, 1986

ANTICIPATED 3 YEAR SAVINGS:

$990 million

HOSPICE EXTENSION

CURRENT LAW:

P.L. 97-248 (TEFRA) authorized medicare part A coverage for hospice care services provided to individuals who are entitled to medicare part A benefits and who are certified to be terminally ill. These provisions of law sunset October 1, 1986. Hospice reimbursement rates have been set on a prospective daily basis.

The Congress agreed to a sunset provision because there was concern that a major review of the legislation would be in order as soon as information could be compiled on the first two years of the hospice benefit. It is clear that there will be no comprehensive data available for review prior to October 1, 1986.

PROPOSAL:

Repeal the sunset provision of current law. Increase each of the daily payment rates by $10.00.

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED 3 YEAR COST:

None

RESPONSIBILITIES OF HOSPITALS IN EMERGENCY CASES

CURRENT LAW:

In order to participate in the medicare program hospitals have to meet certain medicare conditions of participation. There are no specific requirements relating to the appropriate treatment of patients in the emergency room.

PROPOSAL:

a) Medical Screening - for a medicare participating hospital with an emergency department, require an appropriate medical screening examination by appropriate medical personnel, for any individual who requests (or has a request made on his behalf) to determine if any medical emergency medical condition exists or to determine if the patient is in active labor.

b) Necessary Stabilizing Treatment - If the patient is determined to have an emergency condition or is in active labor the hospital must: (i) within the capacities of the institution, provide further examination and treatment as may be required to stabilize the medical condition or to provide treatment for the labor, unless the examination or treatment is refused, or (ii) transfer the patient to another medical facility in accordance with (c) below.

c) Prohibiting Inappropriate Transfers - The hospital may not transfer (or discharge) a patient who has not been stabilized or who is in active labor unless: (i) there has been a written determination by a physician, based upon reasonable risks and benefits to the patient, and based upon the information available at the time, the benefits obtained from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from affecting the transfer; and (ii) the receiving facility has available space and qualified personnel for the treatment of the patient, has agreed to accept the patient and to provide appropriate medical treatment, is provided with the medical records of the examination and treatment provided at the transfering hospital, and the transfer is made with proper personnel and with equipment that meets other health and safety standards of the Secretary.

d) Enforcement

Conditions of paticipation - failure of a hospital to meet these requirements subjects the hospital to termination of its medicare participation agreement.

Civil Monetary Penalties - a medicare participating hospital that knowingly violates requirements of this provision is subject to civil money penalties of not more than $25,000 for each violation.

Civil Enforcement - any person or entity that is adversely affected directly by a participating hospital's violation of these requirements may bring an action, in an appropriate state or Federal district court, for damages to the person arising from the violation and for other equitable relief as may be appropriate to remedy the violation or deter subsequent violations.

Criminal Penalties - The provision imposes a criminal penalty on a responsible physician (see below) who:

(1) has professional responsibilities for the provision of a screening examination of a patient in an emergency department and either:

(a) knowingly fails to provide for any screening examination of a patient in the hospital's emergency department if the failure represents a gross deviation from the prevailing local standards of medical practice,

(b) provides for a screening examination which is conducted in a manner that is so inappropriate as to represent a gross deviation from the prevailing local standards of medical practice, or

(2) has professional responsibilities for the treatment of a patient, knows that the patient has an emergency medical condition or is in active labor, and, within the staff and facilities available at the hospital, either:

(a) knowingly fails to carry out the individual's responsibilities to stabilize the patient if the failure represents a gross deviation from the prevailing local standards of medical practice, or

(b) provides for the treatment in a manner that is so inappropriate as to represent a gross deviation from the prevailing standards of local medical practice or

(3) has professional responsibilities for the treatment of a patient, knows or has reason to know that either the patient has an emergency medical condition which has not been stabilized or the patient is in active labor, and knowingly transfers (or orders the transfer) of the patient either

(a) other than to a medical facility or

(b) to another medical facility and the physician knows (or has reason to know) that the other facility does not have space available for the treatment of the patient or has not agreed to accept the patient.

Penalty - The physican, will be subject to a fine of not more than $100,000 or imprisoned for not more than one year or both, except that if as a direct result of the violation of this provision, the patient dies, the physician shall be fined not more than $250,000 or imprisoned not more than five years or both.

A responsible physician is (i) a physician who is employed by, or under contract with, a medicare participating hospital.

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED 3 YEAR COST:

None

PREVENTIVE SERVICES DEMONSTRATIONS

CURRENT LAW:

Medicare does not generaly provide coverage of preventive health services.

PROPOSAL:

The Secretary would be required to fund at least 5 demonstration projects, under the auspices of schools of public health, to determine whether, and under what conditions it would be cost-effective to include preventive services as a medicare benefit.

The demonstration project would make a number of preventive services available to medicare beneficiaries including health screenings, health risk appraisals, mental health intervention and stress reduction.

Services would be provided by various public health personnel such as physicians, allied health personnel and clincial psychologists.

The Secretary would be required to submit a preliminary report to Congress within 3 years which would include a description of sites at which the programs are being conducted and the services offered.

The Secretary would be required to submit a final report to Congress within 5 years, which would evaluate the costs and benefits of preventive health services. The Secretary would be required to include recommendations in her report with respect to providing preventive health services as a medicare benefit.

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED 3 YEAR COST:

$3 million

HMO TECHNICAL AMENDMENTS

a) FINANCIAL RESPONSIBILITY UPON ENROLLMENT/DISENROLLMENT

CURRENT LAW:

Under current law it is unclear who has responsibility for payment if the medicare beneficiary is an inpatient of a hospital under the prospective payment system on the effective date of his/her TEFRA HMO/CMP election. A similar problem exists for disenrollment.

PROPOSAL:

Enrollment - A TEFRA HMO/CMP would not be financially responsible for reimbursing covered inpatient stays in a PPS hospital if the inpatient stay began before the effective date of enrollment into the TEFRA HMO/CMP. Medicare would reimburse for the inpatient stay, if otherwise covered, as if the beneficiary were not enrolled in the TEFRA HMO/CMP.

Disenrollment - A TEFRA HMO/CMP would be financially responsible for reimbursing for the full inpatient stay in a PPS hospital, if the inpatient stay began before the effective date of disenrollment from the TEFRA HMO/CMP. Medicare would not make a monthly capitation payment nor would it pay for the inpatient stay under the regular medicare program.

EFFECTIVE DATE: OCTOBER 1, 1985

b) EFFECTIVE DATE OF DISENROLLMENT

CURRENT LAW:

Current law requires that the effective date of disenrollment be the first calendar month following a full calendar month after the request is made for termination (1876(c)(3)(B). The current law provisions could result in a delay of up to 60 days between the time the beneficiary requests disenrollment and the effective date of disenrollment. As a result of new computer systems HCFA can now facilitate much faster disenrollment.

PROPOSAL:

Require that disenrollments be effective with the first day of the first month following the month in which the disenrollment request was made. Require that HCFA and the beneficiary receive a copy of the written disenrollment form and that materials be provided to the beneficiary explaining how long he/she must continue to use the HMO/CMP facilities to have the services covered.

EFFECTIVE DATE: October 1, 1985

c) MARKETING MATERIALS

CURRENT LAW:

There are no current law provisions relating to marketing materials. There have been problems with the HMO demonstrations and with some of the ongoing TEFRA HMO/CMPs with marketing materials. Some marketing materials have been misleading, and some have not provided complete information to the medicare beneficiaries.

In the proposed regulations implementing the TERFA HMO/CMP legislation the Secretary would have required review of marketing materials by the Health Care Financing Administration (HCFA) for accuracy and completeness. These provisions were dropped when the final regulations were published.

PROPOSAL:

Require all TEFRA HMO/CMPs to submit all brochures, application forms, promotional and informational materials to HCFA for approval at least 45 days before issuance. HCFA would be required to review all these materials. If the HMO/CMP did not hear from HCFA within the 45-day period the HMO/CMP could assume approval.

EFFECTIVE DATE:

Marketing materials published on or after January 1, 1986.

d) PUBLICATION OF THE AAPCC

CURRENT LAW:

In order to establish the payment amounts to TEFRA HMO/CMPs the Secretary has developed a measure called the Average Adjusted Per Capita Cost (AAPCC). Publication of the AAPCC has been late, causing difficulties for HMOs in their financial planning.

PROPOSAL:

Require the Secretary to publish the AAPCC, annually, no later than September 7.

EFFECTIVE DATE:

October 1, 1985.

TECHNICAL CORRECTIONS

CURRENT LAW:

Current medicare law contains a number of technical errors dating back to TEFRA and DEFRA legislation.

PROPOSAL:

Medicare technical corrections previously included in a proposed technical corrections bill would be included in the budget reconciliation bill. These are as follows:

a) An anamoly in the special enrollment provision would be corrected. It currently permits only one special enrollment period for an individual who was covered under an employer group health plan during his or her initial enrollment period and as a result did not enroll in medicare during such period. Under the bill, such a person would be entitled to unlimited special enrollment periods so long he or she enrolled in medicare during any period during which he or she was not covered by an employer group health plan.

b) Months during which an individual is enrolled in an employer group health plan and is 65 years or over would not be counted in determining a premium penalty for late enrollment. This eliminates the requirement that a person be entitled to part A by virtue of having met the eligibility requirements and having filed for part A benefits.

c) Clerical corrections in spelling, language and indentation in title XVIII of the Social Security Act would be made.

EFFECTIVE DATE:

The changes made by paragraph (a) would apply to the first month that begins more than 90 days after the date of enactment, with certain exceptions.

The changes made by paragraph (b) would apply to months beginning January 1983 for premiums for months beginning with the first month that begins more than 30 days after the date of enactment.

The changes made by paragraph (c) would apply October 1, 1985.

EVALUATION OF PREADMISSION CERTIFICATION PROGRAMS

CURRENT LAW:

Peer review organizations (PROs) are responsible for performing quality and utilization review for hospital inpatient services. In addition to specific objectives contained in the PRO's contract, they are also responsible for DRG validation, review of admissions, review of all transfers and admission pattern monitoring.

Given the incentive of DRG payments to hospitals, PROs have been directed to reduce the rate of inappropriate admissions. PROs perform such admissions review on both a preadmission and retrospective basis. A few PROs are performing 100 percent preadmission review for all non-emergency surgical procedures.

PRO authority is only extended to review of inpatient care. PROs do not currenty have authority to review outpatient treatment.

PROPOSAL:

The Secretary would be required to evaluate the effectiveness of the PRO 100 percent preadmission certification programs in comparison with programs that require less than 100 percent preadmission certification.

Furthermore, the Secretary would be required to evaluate the feasibility of extending the PRO prior approval activities to outpatient and ambulatory settings.

The report to Congress would be due by December 1986.

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED 3 YEAR COST:

None

MEDICARE'S REIMBURSEMENT OF ASSISTANT SURGEONS DURING CATARACT OPERATIONS

CURRENT LAW:

Currently, medicare covers assistant surgeons during routine inpatient cataract operations. Their services are considered reasonable and necessary if it is the generally accepted practice among opthalmologists in the local community to use an assistant surgeon. Some carriers restrict the use of assistant surgeons to cases where medical necessity is established.

PROPOSAL:

The Secretary would be required to establish national guidelines to prohibit medicare reimbursement for assistant surgeons' charges in connection with routine cataract operations. In cases where other medical complications exist, the Secretary would be required to establish procedures under which the primary surgeon could request prior approval from the PRO for the use of an assistant surgeon.

The assistant surgeon would be prohibited from billing medicare or the beneficiary for services which did not receive a prior approval. In addition, the primary surgeon would be prohibited from including charges for the assistant surgeon in his or her bill for such services. The Secretary would have authority to enforce this provision by invoking the penalty provisions provided with respect to violations of the fee freeze.

The Secretary would be required, after consultation with the proposed physician payment advisory group, to develop and report to Congress by April 1, 1986 recommendations regarding other surgical procedures for which an assistant surgeon generally is not medically necessary. Such guidelines would have to provide for procedures under which prior approval for the use of an assistant surgeon could be obtained from the PRO in appropriate cases.

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED 3 YEAR SAVINGS:

$60 million

HOSPITAL-BASED PHYSICIANS

CURRENT LAW:

With the elimination of combined billing arrangements, effective October 1, 1983, carriers established compensation-related customary charges (CRCCs) for hospital-based physicians. Before these physicians could receive customary charge updates based on their actual charges, the CRCCs were frozen into place for 15 months as part of the general medicare fee freeze.

PROPOSAL:

On October 1, 1985, hospital-based physicians (HBPs) whose compensation-related charges were frozen as part of the general medicare fee freeze would, like other physicians, receive increases in their medicare payment based on their actual charges.

Participating HPBs would receive increases that reflect charges they made during the same base period used to update other participating physicians' charges. Nonparticipating HBPs would receive increases that reflect their charges during that period, but deflated to approximate 1982 charges, on which payment to other nonparticipating physicians payment is based.

On October 1, 1986, participating and nonparticipating HBPs would be treated the same as all other participating and nonparticipating physicians.

In order to prevent arbitrary application of the "inherent reasonableness" clause (already in regulations), the Secretary would be required to promulgate regulations which specify explicitly the criteria of "inherent reasonableness." The Secretary would be directed to correct both excessive and deficient charges in accordance with these regulations.

The Secretary has used the "inherent reasonableness" clause in other areas of medicare reasonable charge reimbursement. The regulations which define "inherent reasonableness" would extend to all part B reasonable charge reimbursement.

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED 3 YEAR SAVINGS:

None

LIMIT THE LATE ENROLLMENT PENALTY FOR PART A

CURRENT LAW:

Under current law, part A coverage under medicare is available on a voluntary basis to individuals 65 or over who are not otherwise entitled to coverage. These individuals may obtain medicare part A coverage by paying a monthly premium ($174 in 1985).

Anyone purchasing part A coverage after the third month after the month in which he becomes eligible is charged a late penalty of 10% of the standard premium for each 12 months he is late in enrolling; that is, for each 12 months during which he could have been, but was not enrolled. This penalty is paid each and every month of coverage for the rest of the beneficiary's life.

PROPOSAL:

The part A premium penalty would be limited to 10% no matter how late an individual enrolled, and the period during which the penalty is paid would be limited to twice the number of years enrollment was delayed. At the end of this period, the premium would revert to the standard monthly premium in effect at that time.

EFFECTIVE DATE:

Premiums payable for January, 1986, and thereafter.

ANTICIPATED 3 YEAR COST:

$15 million

END STAGE RENAL DISEASE NETWORKS

CURRENT LAW:

The Secretary is required by statute to establish networks to assure effective and efficient administration of the end stage renal disease program under medicare. The network organizations are responsible for performing functions which include: (1) encouraging the use of treatment settings most compatible with the successful rehabilitation of the patient; (2) developing criteria and standards relating to the quality and appropriateness of patient care; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation; and (3) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities.

PROPOSAL:

The Secretary would be prohibited from dismantling ESRD networks, or from consolidating their organization and functions with Peer Review Organizations or any other entity.

EFFECTIVE DATE:

October 1, 1985

ANTICIPATED BUDGET COST:

None

PRIVATE HEALTH INSURANCE CONTINUATION

CURRENT LAW:

Under current law there are no Federal requirements that private employer group health insurance plans provide continuation or conversion options for any individuals who lose coverage in the health plan under any circumstances.

PROPOSAL:

The business tax deduction for a group health plan would be denied any employer who fails to include in the plan a continuation option to (1) a widowed spouse and dependent children, (2) divorced or separated spouse and dependent children, or (3) medicare ineligible spouse and dependent children. A five year continuation option would be available to the above groups after which time they would be offered the right to convert to an individual policy. The coverage would be identical in scope to the coverage provided under the group plan to similarly situated individuals in the group. The insured spouse would be required to pay both employer and employee share of the premium costs, although the employer could assume the employer share. Coverage would be canceled during the five year period if the employer stopped offering group health coverage, the insured spouse did not pay the premiums or became covered under another group policy or medicare, or the insured spouse remarried.

EFFECTIVE DATE:

January 1, 1986

ANTICIPATED 3 YEAR COST:

None

ALLOW CONTINUED MEDICARE WAIVERS FOR CERTAIN AREAS

CURRENT LAW:

For medicare demonstration projects, normal medicare rules may be waived. When research is completed, however, the normal medicare rules are reinstated.

PROPOSAL:

A local area hospital reimbursement control system that formally operated under a medicare reimbursement waiver would be allowed a continued waiver, at the request of the State, if it locally met conditions imposed Statewide on States that receive a waiver. The system would be required to include substantially all acute care hospitals in its area and review at least 75 percent of revenues or expenses in that area for inpatient hospital expenses and revenue or expenses in the area for inpatient hospital services provided under the State's plan approved under title XIX. Costs would have to be no more than they would be under the PPS system.

This option would be open only to reimbursement systems that were carrying out a demonstration on January 1, 1985 that had been approved by the Secretary of HHS.

EFFECTIVE DATE:

Enactment

ANTICIPATED 3 YEAR COST:

None

MEDICARE COVERAGE FOR NEWLY HIRED STATE AND LOCAL EMPLOYEES

CURRENT LAW:

OASDHI coverage of State and local government employment is not mandatory, but state and local government units are not permitted to withdraw their employees from OASDHI.

PROPOSAL:

For medicare only, coverage would be extended on a mandatory basis to newly hired employees of State and local governmental entities. The employees and their employers would become liable for the hospital insurance portion of the FICA tax.

EFFECTIVE DATE:

Employees hired on or after January 1, 1986.

ANTICIPATED 3 YEAR REVENUES:

$490 million

PROPOSED COMMITTEE REPORT LANGUAGE

HEARING AND APPEALS PROCESS

It has been thirteen years since this Committee has looked substantively at medicare's appeal procedure. Since that time the medicare program has undergone major changes. Inpatient hospital services that were reimbursed on a cost-basis are now subject to the prospective payment system. An increasing number of services once provided only on an inpatient basis are now being provided in ambulatory settings.

As a result of these changes, the Committee believes that the current hearing and appeal procedure under medicare needs to be reviewed. The Committee wants to ensure that adequate procedural safeguards are provided to program beneficiaries and suppliers and providers.

The Committee will, therefore, hold hearing on this issue and, if warranted, take legislative action.

PHYSICAL THERAPISTS

Under current law, part B covers the services of a qualified physical therapist in independent practice when furnished by him or under his direct supervision in his office or in the patient's home. These services must be prescribed by a physician and furnished pursuant to a written plan of treatment established by a physician or a qualified physicial therapist.

The Secretary is required, by statute, to establish conditions that an independently practicing physical therapist must meet in order to receive medicare reimbursement. The Secretary, by regulation, requires that a physical therapist in independent practice maintain an office or office space with the necessary equipment to provide an adequate program of physical therapy. This requirement is applied even to those therapists who operate exclusively in the beneficiary's home.

The Committee believes that the requirement that independently practicing physical therapists who operate exclusively in beneficiaries' homes maintain fully-equipped office is unnecessary. The Committee, therefore, intends that the Secretary eliminate this regulatory provision.

TRADE ADJUSTMENT ASSISTANCE (TAA)

Current Law

TAA programs for trade-impacted workers and firms terminate by statute on September 30, 1985.

TAA for workers consists of trade readjustment allowances (TRA) at unemployment compensation (UC) levels for up to 52 weeks of UC and TRA combined plus up to an additional 26 weeks while in approved training (entitlements); training and other employment services; job search and relocation allowances (discretionary).

TAA for firms consists of financial assistance and/or technical assistance to individual firms or industry-wide (discretionary).

Proposal: H.R. 1926, as amended

H.R. 1926, as amended and reported by the Subcommittee on Trade on July 19, reauthorizes the worker and firm TAA programs for 4 years until September 30, 1989; expands coverage to workers laid off from firms relocated overseas and to firms whose production/sales have declined in significant product lines; increases the collection period and liberalizes prior employment requirements for TRA benefits; makes certain amendments in program administration.

Effective Date: October 1, 1985

Anticipated 3-Year Cost: 0 (see explanation below)

Sections 101-103 of bill (extension to workers laid off from firms relocated overseas, increased TRA collection period, more liberal prior employment requirements) probably increase entitlement costs, but data are unavailable to quantify the amount.

Section 201 of bill (extension to firms with significant product line decline) is likely to increase TAA demand, but unable to determine amount; cost increase depends on whether funds are appropriated to meet additional demand.

Other sections of bill: No cost

INCREASE IN CUSTOMS PERSONNEL

Current Law

The Administration submitted a FY 1986 budget proposal which would have reduced the ranks of the U.S. Customs Service by 887 positions, most of which were front-line personnel such as inspectors, import specialists, patrol officers and agents. The Administration's budget request was $699 million, which included $639 million for salaries and expenses and $60.4 million for the air program.

Proposal

H.R. 2250, as reported by the Subcommittee on Trade: would restore the Administration's proposal cut of 887 Customs positions and add an additonal 800 front-line Customs personnel, allocated among inspectors, import specialists, patrol officers and agent's positons. The increased personnel will result in greater enforcement of our laws and increased revenue collections by the Customs Service which is currently inadequately staffed. The Subcommittee authorizaton level of $769,067,000 provides $718.6 million for salaries and expenses and $50,425,000 for the operation of the Air Program.

Effective Date

The authorization would become effective in FY 1986.

Anticipated 3-year Revenues

It is expected that the additional Customs personnel provided for in the authorization bill will result in a net increase in Customs revenues of $50 million in FY '86, $350 million in FY '87 and $750 million in FY '88 for a 3-year total of $1,150 million.

CUSTOMS USERS FEES

Current Law

The U.S. Customs Service does not currently have the general legal authority to collect fees for the processing of persons, aircraft, vehicles, vessels, and merchandise arriving in or departing from the United States. They do, however, have limited authority to charge fees under certain limited circumstances, such as when they are providing services (such as pre-clearance of passengers and private aircraft) which are of special benefit to a particular individual. They also have the authority to assess fees on operators of bonded warehouses and foreign trade zones and on the entry of vessels into ports and are authorized to receive reimbursement from carriers for overtime for services provided during non-business hours and reimbursement from local authorities for services provided to certain small airports.

Proposal

H.R. 3034, as reported by the Subcommittee on Trade: establishes a fee structure to cover the costs of processing incoming vessels, trucks, trains, private boats and planes and passengers on commercial aircraft, trains and vessels. No fees would be assessed on imported merchandise. The fees would be as follows:

Commercial Vessels:
- Under 100 tons.....$ 25
- 100 or more tons.....$425

Trucks.....$ 5

Trains (per car).....$ 5

Private yachts, boats and general aviation...$ 25 per year

Passenger (train, air and vessel);
- Contiguous countries, U.S. territories and adjacent islands.....$ 1
- Other.....$ 4

Effective Date

The fees would be effective for a 3-year period beginning 180 days after the date of enactment.

Anticipated 3-Year Revenues

It is expected that the bill as reported by the Subcommittee will result in increased revenues of about $173 million per year or $520 million over the 3-year life of the fees.

Amendments Approved by the Subcommittee on Public Assistance and Unemployment Compensation

1

I. RAILROAD UNEMPLOYMENT COMPENSATION

Current Law

The authority for the railroad unemployment compensation system to borrow from the railroad retirement account expires on September 30, 1985. On that date, the outstanding debt to the retirement account is estimated to be $783 million, of which $526 million is principal and $257 million is accumulated interest.

There has been no automatic mechanism in the law to repay loans from the retirement account as they occur. Loans are repaid out of basic contributions to the unemployment account when the Railroad Retirement Board determines that there are sufficient funds in the unemployment account to make a repayment.

The Railroad Retirement Solvency Act of 1983 established a repayment tax that will begin on July 1, 1986 and will expire on September 30, 1990. The tax rate will begin at 2.0 percent and increase by 0.3 percent a year. The tax is paid on the first $7,000 in wages paid to a rail employee.

Proposal

(1) The loan repayment tax, scheduled to begin on July 1, 1986 at a 2% rate with increases of .3% a year, will be increased as follows:

Calendar year	1986	1987	1988	1989	1990
Rate	4.3	4.7	6.0	2.9	3.2

(2) The RRUI Account's authority to borrow from the Railroad Retirement Account is extended, effective October 1, 1985.

(3) An automatic surcharge of 3.5% on an annual wage base of $7,000 will be levied if the RUI Account has to borrow from the retirement account. The surcharge will be used to repay such loans.

Effective Date: October 1, 1985

Anticipated 3-Year Revenues: $199 million

Repayment Tax Proposal

Under both current law and the proposal, the tax begins on July 1, 1986 and ends on September 30, 1990. The current law annual wage base of $7,000 is retained.

		1986	1987	1988	1989	1990	1991	TOTAL
Tax Rate (Calendar Year)	Current Law	2.0	2.3	2.6	2.9	3.2	--	
	Proposal	4.3	4.7	6.0	2.9	3.2	--	
Revenue (In Millions) (Fiscal Year)	Current Law	--	93.7	75.5	81.3	66.5	1.7	318.7
	Proposal	--	194.7	173.4	85.7	66.5	1.7	522.0

II. AFDC QUALITY CONTROL

1. Establish minimum quality control policies and procedures in law.

States would be required to determine the AFDC error rate for each fiscal year in a manner similar to current practice. States could, at their option, collect either 2 six-month samples or an annual sample of their AFDC caseload to develop the error rate but would be prohibited from reducing their sample size.

The Federal re-review, analysis, and notice to the States of the official error rate would have to occur within six months after the close of the fiscal year for which the data are collected or six months from the date a completed State sample is submitted to the Federal regional office, whichever is later.

States would be required to develop and submit to the HHS Secretary a corrective action plan for reducing the identified errors (including those not subject to fiscal penalties as discussed below), the HHS secretary would review and approve the plan, and States would be required to implement the corrective actions.

2. Set a new national standard for the AFDC error rate of 3.5 percent.

3. Determine the adjusted State error rate.

Two adjustments would be made in the raw error rate data collected under item 1 above to produce the adjusted State error rate:

(a) The point estimate of a State's error rate would be the lower bound of the range within which a State's true error rate falls, rather than the midpoint if the State has a sample size sufficient to produce a range of plus or minus 2.5 percentage points or less.

(b) Technical errors would be excluded for fiscal sanctions purposes. These are paperwork omissions which would not change the AFDC payment level. They include: failure to provide evidence in the file of social security numbers, assignment of rights to support, cooperation in obtaining support, WIN registration, and other errors which have no fiscal impact.

4. Recognize that certain factors beyond a State's control influence the error rate by adjusting the standard tolerance level annually for each State.

The standard tolerance level of 4 percent would be adjusted as follows:

(a) Add 0.5 percent to the standard level if the State has operated an AFDC unemployed parent program during the fiscal year.

(b) Add 0.1 percent to the standard level, up to a maximum of 0.5 percent, for each 20 percent increment by which the State: (a) exceeds the national average in terms of percent of total State AFDC caseload with earnings; and/or (b) exceeds the national average in terms of population density (population per square mile of land area).

(c) The steps described in item 3 produce the adjusted State error rate. The steps described in item 4 produce the adjusted State tolerance level.

5. Impose fiscal sanctions on the basis of the adjusted State error rate and the adjusted State tolerance level.

A State's fiscal sanction would be equal to the Federal portion of benefits paid above the adjusted State tolerance level using the adjusted State error rate.

A sanction amount would be reduced by the Federal share of overpayments collected by the State in the fiscal year to which the error rate applies.

The current authority for the HHS Secretary to waive sanctions to acknowledge certain circumstances would be retained and expanded:

(a) States could request a waiver based on the State's good faith effort to reduce errors. In making the waiver request, States would also be permitted to challenge the Federal error rate findings. The HHS Secretary would review and act on the request according to a timetable specified in regulations.

(b) In reviewing the waiver request, the HHS Secretary would be required to consider factors beyond the State's control, factor's related to agency commitment, and other factors as appropriate.

(c) States would be permitted to appeal the Secretary's decision on the waiver request described above to the HHS Grant Appeals Board and could also appeal to the courts.

In lieu of the waiver authority identified above, the Secretary would be required to permanently waive a sanction if the State submits a plan for the reduction of errors which includes the expenditure of additional State administrative funds equal to one-half of the sanction amount. These expenditures would be a Federally-matched administrative expense.

6. SSI Quality Control.

Require the Federal government to continue reimbursing States for the errors it makes in administering the State Supplemental Program (SSP) in SSI. The agreement between the Federal government

and the States promulgated in regulations on March 7, 1979 would be reinstated.

Effective Date: For FY 81 and 82, States would have the option of applying current law (the Michel amendment) or the new quality control system and standards. For FY 83 and thereafter, the new quality control system and standards would apply.

Anticipated 3-Year Cost: $110 million

III. TEENAGE PREGNANCY BLOCK GRANT

Current Law

Although some States are operating pilot service programs for teenage families, comprehensive prevention and service programs do not exist in each State.

Proposal

Authorize a grant program to permit the State AFDC agency to operate a two-part teenage pregnancy program.

(a) Prevention program for AFDC families. These activities would be targeted to male and female children in AFDC families and would include active parent participation. The program would address several factors which have been shown to play important roles in determining teenage sexual activity and contraceptive use. These include low self-esteem and aspirations, ignorance about pregnancy and contraception, fear or embarassment about contraceptive use, and concern about the effect of sexual abstinence or contraceptive use on the relationship.

Children would be encouraged to develop believable education and employment goals for the future and States would combine new and existing resources to assist them to achieve those goals. Such programs would encourage children to postpone sexual activity and child bearing in order to achieve these goals; taking responsibility for family planning would also be stressed.

(b) Comprehensive service program for teenage AFDC parents. Participation would be voluntary; teenage parents who elect to participate would be required to seek a high school degree (or equivalent) and would receive services, including training, day care and transportation, to help them become self-sufficient and avoid long-term welfare dependence. States would be permitted to request a waiver to require participation in the program in jurisdictions with sufficient funding to serve all those who would be eligible to participate.

These new programs would be financed through a block grant to each State. The legislation authorizes the appropriation of $50 million in fiscal year 1986 and $100 million in fiscal year 1987. States would be entitled to receive a grant in each of the two fiscal years for which the program is authorized. Funds could only be used for the purposes specified above. States would be required to target the funds to areas of the State with a high rate of teenage pregnancy and/or a high incidence of infant mortality.

The monies would flow to the State upon submission of a plan in accordance with regulations published by the Secretary of HHS. The plan would have to be approved by the Secretary; the monies could only be used for AFDC eligible individuals, and could not replace funds otherwise allocated for this purpose. A thorough evaluation would be required at the end of fiscal year 1987.

Effective Date: October 1, 1985

Anticipated 3-Year Cost: $150 million

IV. AFDC FOR UNEMPLOYED TWO-PARENT FAMILIES

Current Law

It is a State option to aid needy two-parent families in which the principal earner is unemployed (i.e, the principal earner is working less than 100 hours per month and has six or more quarters of work in any 13-calendar quarter period ending within one year prior to applying for AFDC). Twenty-three States, Guam and the District of Columbia provide this assistance to needy intact families. In the States without a two-parent program, intact families cannot receive assistance or must separate in order to qualify for AFDC.

The States currently without a two-parent AFDC program are the following: Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Maine, Mississippi, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wyoming.

Proposal

Effective October 1, 1986, the proposal mandates that the current AFDC program for unemployed parents be implemented in all States. As a result, all States would aid needy two-parent families in which the principal earner is unemployed.

In addition, the definition of "quarters of work" would be modified to permit the substitution of participation in school or training.

Effective Date: October 1, 1986

Anticipated 3-Year Cost: $390 million

PENSION BENEFIT GUARANTY CORPORATION PREMIUMS

Present Law

The Employee Retirement Income Security Act of 1974 (ERISA) established a program of insurance for employee benefits under most tax-qualified, private, domestic, defined benefit pension plans. The insurance program is administered by the Pension Benefit Guaranty Corporation (PBGC), a Federal corporation within the Department of Labor. Receipts and disbursements of the PBGC are included in the budget of the United States.

Basic benefits under a single-employer plan (generally consisting of nonforfeitable retirement benefits) are insured by the PBGC to the extent of the lesser of $750 per month, adjusted for inflation since 1974 ($1,687.50 for 1985) or a participant's average monthly compensation for the period of 5 years for which that compensation is the highest. The insurance of benefits is generally phased in over a 5-year period.

ERISA provides that the annual per-participant premium for insurance of basic benefits under a single-employer plan is $2.60. The funds maintained by the PBGC to provide benefits under terminated single-employer plans are the sole Federal source of guaranteed benefits for single-employer plans.

The PBGC estimates that the deficit in its single-employer program will be $721 million at the end of its 1986 fiscal year.

Proposal

The annual per-participant premium payable to the PBGC would be increased to $8.00 from $2.60.

Effective Date

January 1, 1986.

Anticipated 3-year Savings

$610 million.

IRS BUDGET FOR FY 1986

Administration's Budget

For fiscal year 1986, the Administration proposed 86,489 positions for the IRS and a total IRS budget of $3.5 billion.

This was a decrease of 1,254 positions and $30.4 million from the fiscal year 1985 appropriation (including requested amounts.

Proposal in Ways and Means Letter

In a letter to the Appropriations Committee, Chairman Rostenkowski, Mr. Pickle, and Mr. Schulze suggested, for fiscal year 1986, that the IRS budget should be increased above the Administration proposal by 1,500 positions and $115 million.

Of the $115 million total, $50 million would be allocated for increased computer capacity and the remainder for salaries for the new positions.

Of the 1,500 positions, 500 would be allocated to enforcement and 1,000 to non-enforcement purposes (primarily processing tax returns and taxpayer correspondence).

Appropriations Committee Recommendation

For fiscal year 1986, the Appropriations Committee voted for an increase over the Administration proposal of $177 million.

Proposal

The Committee on Ways and Means would endorse the recommendation of the Appropriations Committee. That recommendation would restore the Administration's cuts in IRS personnel and would provide for an increase.

Anticipated 3-year Revenues

$1,245 million.

COAL EXCISE TAXES TO FUND BLACK LUNG BENEFITS

Present Law

A manufacturers excise tax is imposed on domestically mined coal (other than lignite) that is sold or used by the producer of the coal (Code secs. 4121, 4218). Under present law, the rate of tax is the lesser of (1) $1 per ton for coal from underground mines and 50 cents per ton for coal from surface mines, or (2) four percent of the price for which the coal is sold.

Amounts equal to the revenues collected from the coal excise tax are automatically appropriated to the Black Lung Disability Trust Fund. The Trust Fund pays black lung disability benefits, under claims filed after 1973, to coal miners (or their survivors) who have been totally disabled by black lung disease in cases where no coal mine operator is found responsible for the individual miner's disease.

The tax rates are scheduled to be reduced by 50 percent on the earlier of January 1, 1996, or any January 1 after 1981 on which there is no balance of repayable advances to the Trust Fund from general revenues and no unpaid interest on such advances.

Proposal

The Administration proposes to increase the tax rate, including the sales price ceiling, as shown in the following chart.

Year(s)	Tax on Underground Coal	Tax on Surface Coal	Ceiling (Percent of Sales Price)
1985	$1.00	$0.50	4.0
1986-1990	$1.50	$0.75	6.0
1991-1995	$1.60	$0.80	6.4
1996-	$1.50	$0.75	6.0

The rates shown for 1996 and later years would not apply beginning two years after the year in which the indebtedness of the Trust Fund has been entirely retired (and no new debt had been incurred). Instead, the present-law rates would be reinstated.

Anticipated 3-Year Revenues

$680 million.

TAX TREATMENT OF RAILROAD RETIREMENT BENEFITS

Present Law

Under present law, a portion of Railroad Retirement system benefits computed by using the social security benefit formula (tier 1 benefits) is subject to Federal income tax for taxpayers whose incomes exceed certain levels (generally, $25,000 for unmarried individuals and $32,000 for married individuals filing a joint return). These benefits may be available at an earlier age under the Railroad Retirement system than under the social security system. Other benefits under the Railroad Retirement system are subject to Federal income tax for all recipients to the extent the payments exceed the amount of the individual's previously taxed contributions to the plan.

Proposal

Under the Administration proposal, certain tier 1 Railroad Retirement benefits would continue to be taxed in the same manner as social security benefits. These benefits are the amount of the annuity under the Railroad Retirement Act of 1974 that would equal the social security benefits to which the individual would have been entitled if all of the individual's employment on which the annuity is based had been employment for social security benefit purposes. In addition, a minimum monthly annuity benefit (described in section 3(f)(3) of the Railroad Retirement Act of 1974) would be taxed in the same manner as social security benefits. Other tier 1 Railroad Retirement benefits would be taxed under the rules that apply to all other payments under the Railroad Retirement system.

Thus, Railroad Retirement disability benefits that are payable to individuals who would not be entitled to social security disability benefits or in an amount in excess of the social security disability benefits to which an individual would be entitled generally would be fully taxable. Similarly, Railroad Retirement benefits that are payable at an age earlier than social security benefits or in an amount greater than social security benefits would be fully taxable.

Effective Date

The proposal would be effective on January 1, 1986.

Anticipated 3-year Revenues

$160 million.

EXTENSION OF PRESENT CIGARETTE EXCISE TAX RATES

Present Law

A manufacturers excise tax equal to $8 per thousand (16 cents per pack of 20) is imposed on small cigarettes. Small cigarettes are cigarettes weighing no more than than three pounds per thousand. Proportionately higher tax rates apply to large cigarettes. Most taxable cigarettes are small cigarettes.

The cigarette excise tax rates are scheduled to decline by one-half (e.g., to 8 cents per pack of 20 small cigarettes) on October 1, 1985.

Proposal

The proposal would make permanent the present cigarette excise tax rates. Thus, small cigarettes would continue to be taxed at 16 cents per pack of 20 cigarettes.

Effective Date

The proposal would be effective on October 1, 1985.

Anticipated 3-year Revenues

$4,900 million.

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